STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155381	A. BUILDING 00 B. WING	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN46060

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 2, 3, 4, 2011 Facility number: 000551 Provider number: 155381 AIM number: 100267400 Survey team: Rita Mullen, RN, TC Michelle Hosteter, RN Heather Lay, RN Census bed type: SNF/NF: 86 Residential: 49 Total: 135 Census payor type: Medicare: 11 Medicaid: 57 Other: 67 Total: 135 Sample: 18 Supplemental sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	**This plan of correction is to serve as Harbour Manor Health and Living Community's credible allegation of compliance.Submission of this plan of correction does not constitute an admission by Harbour Manor Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.Our date of compliance is 12/04/11.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0164 SS=D	Quality review 11/14/11 by Suzanne Williams, RN The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure privacy for a resident in providing care while giving a bed bath for 1 of 1 resident observed receiving personal care in a sample of 18. [Resident #26] Findings include:	F0164	F-164 Personal privacy/confidentiality of recordsI. L.P.N. #4 and C.N.A. #3 have been provided education and have demonstrated satisfactory technique on how to drape and undrape a resident during bathing and provide privacy by pulled curtain as outlined in the ISDH LTC nurse aide training	12/04/2011

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	An observation was made of Resident # 26 while observing LPN # 4 passing medications on 11/2/11 at 11:23 A.M. LPN # 4 had pulled the privacy curtain while preparing to give medications to Resident # 26's roommate. The curtain was pulled and opened a small amount enabling Resident # 26 to be observed at the doorway and out into the hallway. The resident was being washed by CNA #3. The resident had no cover over her body when observed. The curtain was repositioned at this time to provide privacy. At 11:40 A.M. the resident was observed to still be uncovered. The resident indicated to the CNA that she was cold; the CNA stated she would be done shortly. In an interview with LPN # 4 at 11:41 A.M. on 11/2/11, she indicated she was trained that you uncover only the part being washed and then cover the area when done washing. In an interview with the Director of Nursing on 11/2/11 at 4:10 P.M., she indicated she would expect the CNA to cover the resident while giving a bed bath. 3.1-3(o)		program.II. Other C.N.A.'s are being observed during bathing of residents to identify that proper procedure for draping and undraping is performed correctly to maintain the privacy and warmth of the resident during the bathing process to include a pulled curtain. C.N.A.'s not draping and undraping residents appropriately are required to attend additional training/re-education.III. Each C.N.A. will be observed performing the procedure for draping and undraping a resident during a bath. Those identified as not performing the task properly will receive additional education and then be required to demonstrate the technique until procedure for draping and undraping a resident is satisfactorily demonstrated to include privacy by pulled curtain.IV. The Staff Development Coordinator or Designee will observe 3 bed baths per week for 2 months to monitor for compliance with draping and undraping of a resident during a bed bath to include a pulled curtain. The random observations will continue at a rate of 1 bed bath per week for 4 months. These audits/observations will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions.V. Date of	

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to update a resident's plan of care regarding specific speech therapy recommendations for a resident with risk of aspiration, a wound clinic recommendation for no briefs while in bed and to develop a plan of care for a resident with behaviors. The deficient practices impacted 3 residents of 18 residents reviewed for care plans in a sample of 18. (Residents #5, 13 and 26) Findings include: 1. Resident #5's record was reviewed on 11/1/11 at 11:00 A.M. Diagnoses included, but were not limited to,	F0279	compliance – 12/04/11 F-279 Develop comprehensive care plansI. Resident #5 no longer resides in the facility. Resident # 13's care plans were reviewed and updated as needed to include behavior care plans. Resident # 26's care plans were reviewed and updated as needed to include skin interventions related to briefs and positioning.II. All other residents care plans have been reviewed and updated to include identification of ST recommendations, behavior interventions, and skin/ulcer interventions (ie: positioning).III. All nurses and therapy staff have been provided education on initiating and updating care plans. ST recommendations are	12/04/2011

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	dysphagia, aspiration pneumonia, Alzheimer's disease, osteoarthritis, and chronic pain. A speech therapy "Plan of Treatment" dated 7/27/11, included, but was not limited to, "Reason for Referral: Patient [Resident #5] with decline effecting her ability to safely chew and swallow food/liquid. Precautions: Puree diet, thin liquids - no straws... Assessment: Patient demonstrated a delayed swallow initiation of about 5 seconds with thin liquids. Recommend no straws... ST [Speech Therapy] to treat patient for dysphagia and educate staff on safe swallow strategies..." A "Speech Therapy Progress Report" dated 7/27/11 through 8/18/11, included, but was not limited to, "Treatment of swallowing dysfunction and/or oral function for feeding... Response to Treatment: Patient [Resident #5] is tolerating current diet of puree consistencies and thin liquids (no straws). Positioning impacts tolerance to diet... Caregiver Education: Ongoing..." A dietary "Progress Note" dated 9/7/11 at 1:07 P.M. included, but was not limited to, "Resident is being treated for a respiratory infection... she is on a NAS [no added salt], puree diet..."		communicated through the morning meeting process.The systemic change is that Unit Managers and Therapy will bring all new physician orders (to include diet order change slips to be completed for any ST recommendation) and recommendations, 24 hour reports, and other pertinent information regarding any changes in a residents condition to the morning clinical meeting for review and updating of care plan 5 days per week.IV. The Director of Nursing and/or Care Plan Coordinator will review the plan of care for 5 residents weekly for 2 months, then 3 residents weekly for 4 months to monitor for compliance with the initiation and/or updating of the care plans to include ST recommendations, behaviors, and skin interventions related to briefs and positioning.These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions.V. Date of compliance – 12/04/11	

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	A care plan included, but was not limited to, "Problem Start Date: 8/3/11, Resident requires a therapeutic diet related to hypertension, renal insufficiency, cardiac conditions, and hyperlipidemia... Approach: Diet: Regular, NAS or per current orders, Monitor and record intake of food, and offer available substitutes if resident has problems with the food being served..." In an interview on 11/3/11 at 10:55 A.M., LPN [licensed practical nurse] #1 indicated Resident #5 was encouraged fluids, such as water, with a straw. Regarding communication with speech therapy, LPN #1 indicated speech therapy verbally communicates individual resident needs. LPN #1 indicated she was not aware of speech therapy's recommendation of "no straw" when encouraging fluids. In an interview on 11/3/11 at 11:30 A.M., Speech Therapy #1 indicated the speech therapy department verbally communicates all recommendations to nursing staff. She indicated education of staff was completed regarding Resident #5's feeding interventions, which included "no straw" use with liquids. Speech Therapy #1 indicated the facility does not utilize a log for completed staff education.			

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	In an interview on 11/3/11 at 11:45 A.M., the DoN [Director of Nursing] indicated she was aware the use of verbal communication for recommendations did not work between speech therapy and nursing. 2. The clinical record of Resident #13 was reviewed on 11/2/11 at 11:15 A.M. Resident's admitting date at the facility was 7/2/11. Diagnoses for Resident #13 included, but were not limited to, dementia, depression, glaucoma and kidney disease. A quarterly Minimum Data Set assessment, dated 9/30/11, indicated Resident #13 had severely impaired decision making skills. A Nursing note, dated 7/3/11 at 10:06 A.M., indicated, "Res (Resident) refuses to allow staff to assist to bathroom or with dressing. Res incontinent of bladder at this time and refusing to allow staff to assist with changing/cleaning. This writer and CNA attempted to encourage res to walk to bathroom, res attempted to kick and hit staff..." A Nursing note, dated 7/3/11 at 1:47 P.M., indicated, "Family came in at 1045 this shift and spoke with res. Res agreed			

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	to get dressing (sic) and receive assistance with peri care and ambulation after strong encouragement from family...." A Social Service note, dated 7/5/11 at 11:21 A.M., indicated, "...This writer spoke with (name) on the phone today and we set a time for the initial care plan meeting which will be on 7/5/11 at 3:00 P.M. A Nursing note, dated 7/15/11 at 11:30 P.M., indicated "Resident up walking around with walker and wanting to find 'the boys so she can go. (sic)' She is wandering up and down hall and attempting to get into other resident's rooms. She became combative with staff when they tried to stop and redirect her. She was pounding on doors to get out and insisted that staff leave her alone. Resident standing by front door and lost balance and fell on buttocks. She was combative and smacking staff when attempting to get her off the floor. No s/s (signs and symptoms) of injury from fall....Dr. (name) notified of fall and of behavior. New orders received. Haldol (an antipsychotic) attempted to be given and resident was combative while medication was given." A Nursing note, dated 7/16/11 at 1:30 A.M., indicated "Resident calmed down			

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	for awhile and sat in chair in lounge. She remains alert and continues to say she was going to leave. She has now started to want to get up and leave and insists that she was going to go. She got out of chair and started to go to the doors again and smacking at staff. Haldol IM (injection) repeated at this time." A Nursing note, dated 7/16/11 at 3:17 A.M., indicated "Remains insistent about going home and has attempted several times to get out of chair. She is sitting in recliner in lounge." A Nursing note, dated 7/17/11 at 11:15 A.M., indicated "Res has been in bed all the day, refusing to get OOB (out of bed). Refused all medications this morning and was nonverbal to this nurse. Alert and refusing to speak. Allowed this nurse to get all vital signs except temperature. Refused to open mouth for thermometer and refused for this nurse to put thermometer under arm." A Social Service note, dated 7/27/11 at 5:39 P.M., indicated "...on 7/24/11, resident woke up and stated to staff that 'it's like a hook was there and I have a handle on all of this.' There have not been any behaviors since....Resident has dx (diagnoses): Dementia with behavioral disturbance; Depression, Alzheimer's.			

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	(Name of Resident) receives Ativan (antianxiety), Sertraline (antidepressant), Zyprexa (antipsychotic)....(name of Resident) is care planned for anger regarding placement; altered cognition; HOH (hard of hearing)." A Behavior Monitoring Record, no date on the form, received from Social Service designee #9, on 11/3/11 at 10:44 A.M., indicated Resident #13 had the following behaviors: wander into others rooms, cursed at staff, kicks staff, hitting staff, resists care, refuses showers, removes O2 and refuses to speak at times. During an interview with Social Service designee #9, on 11/3/11 at 10: 44 A.M., she indicated a behavior care plan for Resident #13 had not been done. 3. The clinical record of Resident #26 was reviewed on 11/3/11 at 1:05 P.M. Diagnoses included, but were not limited to, dementia with behaviors, failure to thrive, and open buttocks wound. A quarterly Minimum Data Set assessment, dated 10/5/11, indicated a Brief Interview of Mental Status score of 4 out of 15, required the extensive assist of two staff members for transfers, the assist of one staff member for meals and a stage IV pressure ulcer.			

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	A Care Plan for "At risk for further skin breakdown," dated 10/8/10, indicated Resident #26 was a risk due to decreased mobility, poor cognition, poor circulation, refusal to be laid down frequently, chronic incontinence of bowel and bladder, weight loss and a history of previous ulcers. Approaches were started on 10/8/10 and up-dated on 10/26/10, 9/22/11 and 10/19/11. Approaches were as follows: 10/8/10: Assist with turning and repositioning as needed. Monitor labs as ordered. Notify family and Dr. as needed. 10/26/10: Provide diet as ordered. Provide supplements as ordered. Use Hoyer lift for transfers. 9/22/11: Notify family and Dr. as needed. Observe for pain and discomfort, assist as needed. Provide incontinence care after each incontinence episode. Report any signs of skin breakdown. 10/19/11: Prevalon boots bilaterally as patient tolerates. Use gel cushion when she is in chair. Use low air loss mattress when she is in bed. A review of the Weekly Wound Evaluation sheets indicated the following			

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	pressure areas: 10/22/10: A stage II on the coccyx. 10/22/10: A stage II on the left side of sacrum. 10/29/10: A stage II on the left buttock. The care plan was not up-dated. 12/8/10: A non-pressure wound on coccyx. The care plan was not up-dated. 12/8/11: A non-pressure wound to the left buttocks. The care plan was not up-dated. 12/23/10: A stage III on the sacrum. The Care Plan was not up-dated. 2/8/11: An unstageable on the coccyx. A new Care Plan was started for a Stage IV pressure ulcer on 2/10/11. Wound Clinic Progress notes were reviewed for the months of October 2010 through February 2011. The following recommendations were made on the following dates: 10/29/10: Low air loss mattress, foam in wheelchair. 12/10/10: Low air loss mattress, no briefs			

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	in bed, house shakes and med pass. 2/11/11: Offload. 2/18/11: Turn/reposition frequently, offload. A Care Plan for a stage IV pressure ulcer, dated 2/10/11, indicated a pressure ulcer to the coccyx. Approaches were started on 2/10/11 and up-dated on 2/11/11 and 5/11/11. Approaches were as follows: 2/10/11: Use gel cushion for pressure reduction when resident is in chair. Turn and reposition as needed. Supplements: as ordered. Provide incontinence care after each incontinent episode. Notify Dr. and family of any changes. Monitor weight as needed. Notify MD and family of significant weight change. Monitor lab work: as needed. Low air loss mattress. Provide diet as ordered. Assess the pressure ulcer. Assess resident for pain. Apply treatments as ordered. The recommendation for no briefs in bed was not included on the Care Plan nor was the frequency of reposition increased or offloading while the Resident was up in the wheelchair. 2/11/11: Monitor for infection.			

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	2/25/11: Med Pass and Prostat as ordered. 5/11/11: Patient placed on Hospice and to monitor area, also. During an interview with LPN #10, on 11/3/11 at 10:00 A.M., she indicated if the number of times the resident was supposed to be repositioned were on the care plan then they would have to prove the repositioning was done and that no briefs in bed was not on the care plan. 3.1-35(a) 3.1-35(b)(1)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on record review and interview, the facility failed to follow the care planned recommendations of the Speech Therapist for a resident with swallowing problems. This effected 1 of 4 residents reviewed for weight and nutrition concerns in a sample of 18. (Residents #5) B. Based on observation, record review and interview, the facility failed to ensure proper administration of medication according to the physician's sliding scale order of insulin for 1 of 1 resident	F0282	F-282 Services by qualified persons/per care plan I. Resident # 5 no longer resides in the facility. Resident # 43's insulin orders have been reviewed and clarified if indicated. Resident # 43 is receiving insulin as ordered by the Physician. II. All other residents with ST recommendations have been identified and have had their care plans reviewed and updated as needed. Staff will be educated on identifying interventions on care plans and staff will follow.	12/04/2011

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	observed for insulin administration in a supplemental sample of 4. [Resident #43] Findings include: A. Resident #5's record was reviewed on 11/1/11 at 11:00 A.M. Diagnoses included, but were not limited to, dysphagia, aspiration pneumonia, Alzheimer's disease, osteoarthritis, and chronic pain. A speech therapy "Plan of Treatment" dated 7/27/11 included, but was not limited to, "Reason for Referral: Patient [Resident #5] with decline effecting her ability to safely chew and swallow food/liquid. Precautions: Puree diet, thin liquids - no straws... Assessment: Patient demonstrated a delayed swallow initiation of about 5 seconds with thin liquids. Recommend no straws... ST [Speech Therapy] to treat patient for dysphagia and educate staff on safe swallow strategies..." A "Speech Therapy Progress Report" dated 7/27/11 through 8/18/11 included, but was not limited to, "Treatment of swallowing dysfunction and/or oral function for feeding... Response to Treatment: Patient [Resident #5] is tolerating current diet of puree consistencies and thin liquids (no straws).		All other residents with insulin orders have been reviewed, clarified as needed and staff have received education regarding 2 nd nurse verification. III. All nursing and therapy staff have been educated on following care plans, communication of recommendations, and insulin administration per Physician order to include 2 nd nurse verification. The systemic change is that Unit Managers and Therapy will bring all new physician orders, speech therapy recommendations in the form of diet order change slip, 24 hour reports, and other pertinent information regarding any changes in a residents condition to the morning clinical meeting for review and updating of the care plan 5 days per week. Also, the systemic change includes that all sliding scale insulin and routine insulin will have a 2nd nurse verification and signature on the MAR before administration to ensure dose is administered as ordered. IV. The Director of Nursing or Designee will review all Therapy recommendations daily 5 days per week for 3 months, then all Therapy recommendations one time weekly for 3 months. The DON or Designee will audit a nurses insulin administration 2 times per day, 5 days a week for 2 months, and then audit a nurse 2 times per day once a week for 4 months.	

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	Positioning impacts tolerance to diet... Caregiver Education: Ongoing..." A dietary "Progress Note" dated 9/7/11 at 1:07 P.M. included, but was not limited to, "Resident is being treated for a respiratory infection... she is on a NAS [no added salt], puree diet..." A care plan included, but was not limited to, "Problem Start Date: 8/3/11, Resident requires a therapeutic diet related to hypertension, renal insufficiency, cardiac conditions, and hyperlipidemia... Approach: Diet: Regular, NAS or per current orders, Monitor and record intake of food, and offer available substitutes if resident has problems with the food being served..." In an interview on 11/3/11 at 10:55 A.M., LPN [licensed practical nurse] #1 indicated Resident #5 was encouraged fluids, such as water, with a straw. Regarding communication with speech therapy, LPN #1 indicated speech therapy verbally communicates individual resident needs. LPN #1 indicated she was not aware of speech therapy's recommendation of "no straw" when encouraging fluids. In an interview on 11/3/11 at 11:30 A.M., Speech Therapy #8 indicated the speech		These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of compliance – 12/04/11	

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	therapy department verbally communicates all recommendations to nursing staff. She indicated education of staff was completed regarding Resident #5's feeding interventions, which included "no straw" use with liquids. Speech Therapy #1 indicated the facility does not utilize a log for completed staff education. In an interview on 11/3/11 at 11:45 A.M., the DoN [Director of Nursing] indicated she was aware the use of verbal communication for recommendations did not work between speech therapy and nursing. B. An observation on 11/2/11 at 11:15 A.M. Resident # 43's blood sugar was checked. His blood sugar was 214. LPN #7 indicated according to the sliding scale order from the physician, the resident was to receive 4 units of Novolog subcutaneously for blood sugar reading in a range of 200-215 The resident also receives a standing dose of Novolog insulin of 24 units at 11 A.M.. LPN #7 indicated the total amount of insulin to be given should be 28 units of Novolog. LPN # 7 was observed to draw 24 units of Novolog insulin and injected subcutaneously in the residents lower right abdomen. The record for Resident #43 was reviewed on 11/02/11 at 12:05 p.m. Resident #43's			

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	physician recapitulation [a summary of all current physician's orders] indicated to give, "... for a fasting blood sugar of 200-215, 4 units of Novolog insulin...." In an interview with LPN #7 immediately following the administration of insulin, she indicated that she did not give the dose of sliding scale of 4 units of insulin ordered; she only drew and gave the 24 units of Novolog for the standing order. She then drew 4 units of Novolog and administered to the resident after explaining to the resident she had only given the 24 units of Novolog. 3.1-35(g)(2)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview and record review, the facility failed to be proactive in the prevention of pressure ulcers for a resident with a history of pressure ulcers on the coccyx. This affected 1 of 6 residents reviewed for pressure ulcers in a sample of 18. (Resident #26)	F0314	F-314 Treatment/Services to prevent/heal pressure sores I. Resident # 26's recommendation for "no briefs in bed" has been discontinued by the Physician. Resident # 26's care plan has been updated to include the frequency of repositioning as resident tolerates and to include the	12/04/2011

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	Findings include: The clinical record of Resident #26 was reviewed on 11/3/11 at 1:05 P.M. Diagnoses included, but were not limited to, dementia with behaviors, failure to thrive, and open buttocks wound. A quarterly Minimum Data Set assessment, dated 10/5/11, indicated a Brief Interview of Mental Status score of 4 out of 15, required the extensive assist of two staff members for transfers, the assist of one staff member for meals and a stage IV pressure ulcer. A Care Plan for "at risk for further skin breakdown," dated 10/8/10, indicated Resident #26 was a risk due to decreased mobility, poor cognition, poor circulation, refusal to be laid down frequently, chronic incontinence of bowel and bladder, weight loss and a history of previous ulcers. Approaches were started on 10/8/10 and up-dated on 10/26/10, 9/22/11 and 10/19/11. Approaches were as follows: 10/8/10: Assist with turning and repositioning as needed. Monitor labs as ordered. Notify family and Dr. as needed. 10/26/10: Provide diet as ordered. Provide supplements as ordered. Use		frequency of off-loading while resident is up in wheelchair. Resident # 26 currently has a care plan in place for each actively open pressure ulcer with appropriate interventions. II. All other residents with current pressure ulcers have been identified and have had their care plans reviewed for interventions to include recommendations by new wound NP starting with the facility November 1, 2011. All other residents with an admitted or acquired pressure ulcer will be evaluated by a weekly wound evaluation/observation and a care plan will be initiated at the time of identification to include appropriate interventions based on their risk. III. All nurses have been educated on identification of pressure ulcers, measurement, and initiation of care plan for residents with pressure ulcers. All C.N.A.'s have been educated on following the residents plan of care and C.N.A. assignment sheet to include turning and repositioning in bed and "off-loading" when up in wheelchair. The systemic change is that all newly identified or newly admitted residents with pressure ulcers will be reported immediately to the ADON/Designee. The ADON/ Designee will ensure the care plan is initiated timely for each wound with appropriate interventions based on	

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	Hoyer lift for transfers. 9/22/11: Notify family and Dr. as needed. Observe for pain and discomfort, assist as needed. Provide incontinence care after each incontinence episode. Report any signs of skin breakdown. 10/19/11: Prevalon boots bilaterally as patient tolerates. Use gel cushion when she is in chair. Use low air loss mattress when she is in bed. A review of the Weekly Wound Evaluation sheets indicated the following pressure areas: 10/22/10: A stage II on the coccyx. 10/22/10: A stage II on the left side of sacrum. 10/29/10: A stage II on the left buttock. The care plan was not up-dated. 12/8/10: A non-pressure wound on coccyx. The care plan was not up-dated. 12/8/11: A non-pressure wound to the left buttocks. The care plan was not up-dated. 12/23/10: A stage III on the sacrum. The care plan was not up-dated.		the residents' risk. Also, the systemic change is that the ADON/Designee will review all wound N.P.'s recommendations/documentation and will update the care plan at that time. IV. The DON or Designee will audit 5 care plans of residents with pressure ulcers weekly to audit for date of initiation of care plan, wound clinic recommendations, and repositioning interventions based on risk. This audit will continue at a rate of 5 residents CP's weekly for 3 months, then 5 residents every 2 weeks for the following 3 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of compliance – 12/04/11	

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2/8/11: An unstageable on the coccyx. A new care plan was started for a Stage IV pressure ulcer on 2/10/11.

Wound Clinic Progress notes were reviewed for the months of October 2010 through February 2011. The following recommendations were made on the following dates:

10/29/10: Low air loss mattress, foam in wheelchair.

12/10/10: Low air loss mattress, no briefs in bed, house shakes and med pass.

2/11/11: Offload.

2/18/11: Turn/reposition frequently, offload.

A Care Plan for a stage IV pressure ulcer, dated 2/10/11, indicated a pressure ulcer to the coccyx. Approaches were started on 2/10/11 and up-dated on 2/11/11 and 5/11/11. Approaches were as follows:

2/10/11: Use gel cushion for pressure reduction when resident is in chair. Turn and reposition as needed. Supplements: as ordered. Provide incontinence care after each incontinent episode. Notify Dr. and family of any changes. Monitor weight as

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	needed. Notify MD and family of significant weight change. Monitor lab work: as needed. Low air loss mattress. Provide diet as ordered. Assess the pressure ulcer. Assess resident for pain. Apply treatments as ordered. The recommendation for no briefs in bed was not included on the Care Plan nor was the frequency of reposition increased or offloading while the Resident was up in the wheelchair. 2/11/11: Monitor for infection. 2/25/11: Med Pass and Prostat as ordered. 5/11/11: Patient placed on Hospice and to monitor area, also. During an interview with LPN #10, on 11/3/11 at 10:00 A.M., she indicated if the number of times the resident was supposed to be repositioned were on the care plan then they would have to prove the repositioning was done. 3.1-40(a)(2)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to follow the recommendations of the Registered Dietitian and implement nutritional interventions for a resident with significant weight loss. This effected 1 of 4 residents reviewed for weight and nutrition concerns in a sample of 18. (Resident # 26) Findings include: 1. During the initial tour with LPN #1 , on 10/31/11 at 11:00 A.M., Resident #26 was identified as a resident with weight loss and pressure ulcers. The clinical record of Resident #26 was reviewed on 11/3/11 at 1:05 P.M. Diagnoses included, but were not limited to, dementia with behaviors, failure to thrive, and open buttocks wound. A Registered Dietician (RD) note, dated	F0325	F-325 Maintain Nutrition status unless unavoidable I. Resident # 26's orders currently reflect all RD recommendations. II. All residents in which the RD completes audits and makes recommendations for are at risk and have been identified. Current RD recommendations for residents have been reviewed and have been communicated to the Physician for any required orders. III. Nursing management has been educated on the communication process for RD recommendations. The systemic change is that the ADON/Designee will receive a copy of the RD recommendation upon the RD's visit. The ADON/Designee will provide a copy of the recommendations to the assigned Unit Manager. The Unit Manager will follow up for each recommendation to include any Physician orders as needed. A copy of the acquired order or update will then be provided back to the ADON/Designee. A log will be kept.	12/04/2011

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	10/6/10, indicated "Resident current weight of 120#s (pounds) is sign (significant) loss 5.9% past 30 and 10.3% 180 days. R/T (related to) recent hospitalization for hypoxemia and pneumonia, illness w/ (with) decreased intakes. Noted weight loss of 9# x 2 weeks, at hospital. Weight has fluctuated past 6 months, noted stable past 90 days. Intakes since return: 44% meals; 1210 ml (milliliters) fluids per day. Meal intake less than assessed need due to illness. Fluid intake adequate. Labs at hospital were WNL (within normal limits). Rsd (resident) remains ill, sent back to hospital today for shortness of air, resp (respiratory) issues. Rec (recommend) when rsd returns, offer 60 ml med pass supple (supplement) TID (three times a day)." An IDT (interdisciplinary team) note, dated 10/13/10, indicated "IDT weekly review for wt loss. This weeks wt on 10/13/10 was 110.9lb which is a loss 9lb since 10/5/10. Resident continues to not eat well, Receives regular NAS (no added salt) diet. Dietary provides serbert (sic) lunch and dinner. Continues to consume 0-25% of most meals along with frequent refusals....New interventions to include magic cup at lunch and dinner. Will continue to review weekly." There was no indication the recommendation from		IV. The DON/Designee will audit the RD recommendations weekly by audit of the ADON/Designee log and return information from Unit Manager for completion. This audit will continue weekly for 6 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of Compliance – 12/04/11	

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	10/6/10, by the RD of 60 ml med pass, was being offered TID. An IDT note, dated 10/27/2010, indicated "IDT review for significant wt. loss of 16.6% in 30 days. Current wt on 10/20/10 was 107.8lb, which is a 2.4lb loss from previous week....Receives magic cup at lunch and dinner and med pass....Resident is currently being treated for open areas to right and left gluteal fold. Will request form MD initiation of vitamin D, Vitamin C and Zinc and request a Prealbumin level...." An IDT note, dated 11/17/10, indicated "IDT review for a weight loss of 13.8% loss in 90 days. Current weight on 11/11 was 108.5 which was a 0.1 weight loss in one week....She receives a Magic cup at lunch and dinner and a Health shake at breakfast and dinner....Wounds to gluteal fold are healed. Resident continues to be offered med pass but usually will only consume 50% or less...." An IDT note, dated 11/26/10, indicated "Resident being reviewed today for ongoing weight loss. Resident continues to have poor intake....Resident's current weight on 11/25/10 is 106.6. Resident receives health shakes at breakfast and dinner, a magic cup at lunch and dinner....New order requested today for			

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	Med Pass 60cc (cubic centimeters) TID...." This recommendation had been made on 10/06/10 by the Registered Dietician. The October 2010 Medication Administration Record (MAR), for documentation of the Med Pass, was requested from the Director of Nursing, on 11/4/11 at 2:00 P.M. As of 11/4/11, at 4:30 P.M. at the time of the exit, the MAR was not presented. During an interview with the Director of Nursing, on 11/4/11 at 4:00 P.M., she indicated the October 2010 MAR, did not indicate Resident #26 received Med Pass during the month of October. 3.1-46(a)(1)			
F0364 SS=D	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure proper food temperatures for 3 of 3 residents receiving room trays in a supplemental sample of 4. [Resident #18, Resident #19, and Resident #57] Findings include:	F0364	F-364 Nutritive value/appearance, palatable/preferred temperature I. Resident # 18, 19, and 57 will receive meals/food at proper temperature. II. All residents have the potential to be affected and have been identified. All residents will receive meals within approved temperature.	12/04/2011

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	In an observation of the serving of food trays to the residents in their rooms on 11/4/11 at 12:00 P.M. The cart was followed from the kitchen after trays had been placed onto the cart, to the last room served. A test tray was checked with the Clinical Nurse Specialist and the food temperatures at 12:15 P.M. were as follows: fish- 109 degrees, macaroni and cheese- 123 degrees, and cole slaw- 63 degrees. The food was tasted and was warm, but not hot. Residents #18, #19, and #57 indicated in the group meeting on 11/2/11 at 2 P.M. that their food was cold when they got to their rooms. In an observation on 11/4/11 at 12:25 P.M. with the Director of Dining Services, the plate warmer which they use to dish and serve the food to the resident was indicated by the Director of Dining Services to be" barely warm to the touch." 3.1-21(a)(2)		III. Education has been provided to all dietary staff in relation to proper food temperatures. The systemic change is that all room trays will have a pellet under and a cover over the hot food items to ensure appropriate temperatures. The systemic change also includes that the cold food area is designated on top of the food cart and is "iced down" and covered to ensure all cold food items remains cold. Also, the plate warmer setting has been increased to ensure appropriate temperatures for plates. I. The DM/Designee will audit one meal, to include 3 room trays 5 days per week for 2 months for proper temperatures. The audit will continue at a rate of one meal, to include 1 room tray 3 days per week for the next 2 months. The audit will then be at a rate of one meal, to include one room tray per week for 2 months to include room trays. The DM/Designee will interview Resident # 18, 19, and 57 3 times per week to ensure appropriate food temperatures received. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. IV. Date of compliance – 12/04/11	

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure thawing food using proper technique and to ensure proper use of hairnets by employees for 1 of 1 kitchen. This had the potential to affect 85 residents receiving food from the kitchen of 86 residents in the facility. Findings include: A. During observation of kitchen on 11/3/11 at 9:05 A.M. a ham was thawing in standing water in the three compartment sink. The temperature of the water was 71.6 degrees and the core temperature of the pre-cooked ham was 39.6 degrees. In an interview on 11/3/11 at 9:06 A.M. with the Dietary Aid #6, he indicated he had set the ham out at 8 A.M. and they were going to use it for lunch tomorrow. In an interview with the Dietary Services Manager on 11/3/11 at 9:07 A.M., he indicated dietary staff are expected to thaw food in the refrigerator on a tray. B. An observation was made on 10/31/11	F0371	F-371 Food procurement, storage/preparing/serving – sanitary I. No residents found to be affected. II. All residents are at risk to be affected and have been identified. Ham was not served as referenced in the 2567. Dietary aide identified not wearing a hair net was educated and given a written warning. Thawing procedures and hairnet procedures will be followed by all dietary staff. III. Dietary staff has been educated on the proper protocol to thaw all meat and proper food handling. Dietary staff has also been educated on appropriate use of hairnets. The systemic change is that a "prep sheet" has been put in place to make all dietary staff aware of what items are to be pulled and the proper way in which to thaw the item. The systemic change also includes daily auditing of hairnet usage by staff. IV. DM/Designee will audit thawing of meat items 5 days a week for 2 months, then continue audit of thawing at a rate of 3 days per week for 4 months. DM/Designee will audit staff usage of hairnets randomly 5 days per week for 2 months, and then	12/04/2011

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	155381	A. BUILDING 00 B. WING	11/04/2011

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	at 11:45 A.M. Dietary Aide # 5 had no hairnet on and was assisting with drinks and putting trays onto the cart for residents eating in their room. In an interview with the Dietary Services Manager on 11/3/11 at 9:15 A.M., he indicated that all employees should have hairnets on while working on serving line. 3.1-21(i)(3)		continue the audit randomly 3 days per week for 4 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of compliance – 12/04/11	

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure correct labeling for eye drops for 1 of 2 residents observed during med pass for correct medication labeling in a supplemental sample of 4. [Resident # 27] Findings include:	F0431	F-431 Drug records, labels/store drugs and biological I. Resident # 27's eye drops were completed and discontinued on 11/11/11 as ordered by Physician. II. Residents with Physician orders for eye drops have been identified and those residents	12/04/2011

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	The medication pass was observed for Resident #27 on 11/2/11 at 11: 25 A.M.. LPN #2 was preparing to give Resident #27 her Prednisone 0.1% eye drops. The label on the container was observed to indicate to give one drop to right eye every day beginning 9/27/11. The order on the MAR (Medication Administration Record) indicated that the Prednisone 0.1 % eye drops were to be given one drop to the left eye daily starting 10/11/11. In an interview with LPN #2 on 11/2/11 at 11:26 A.M. she indicated the resident had cataract surgery on both eyes and that this is where the labeling error may have occurred. She indicated the order on the MAR was the correct order. The physician's order recapitulation indicated the correct order was to be giving one drop to the left eye daily of the Prednisone 0.1 %. In an interview with the DON (Director of Nursing) on 11/2/11 at 3:15 P.M., she indicated she was unaware of the labeling error. 3.1-25(j) 3.1-25(k) 3.1-25(l)		have labels as ordered by the Physician. III. Education has been provided to licensed nurses regarding administration of medications to include eye drops. The education includes the 5 rights of medication administration. The systemic change is that eye drops will be audited by a Unit Manager upon arrival from Pharmacy and then weekly to ensure eye drops are labeled as ordered. The systemic change also includes that any change in Physician order for eye drops will include the nurse obtaining the order to place a "directions changed refer to chart" sticker on the eye drop container/package. I. The DON/Designee will audit medication carts to include eye drops 3 times a week for 2 months to ensure labeling as ordered by the Physician. The audit will then continue one time per week for 4 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. IV. Date of compliance – 12/04/11	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure the sanitation of glucometer after use for 1 of 2 residents observed for correct sanitation procedures during a medication pass in a	F0441	F-441 Infection control, prevent spread, linens I. Resident # 43 will receive glucometer checks by use of a sanitized glucometer machine per	12/04/2011

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	supplemental sample of 4 [Resident #43]. Findings include: In an observation on 11/2/11 at 11:15 a.m. Resident # 43 's blood sugar was checked. LPN # 2 checked the resident's blood sugar and then placed the glucometer back into the drawer of the medication cart without cleaning or sanitizing the glucometer. The nurse indicated she was done doing blood sugars at this time and that this glucometer is used for the residents on this hallway. In an interview with the DON on 11/2/11 at 4:05 P.M. she indicated that she expects the staff to clean the glucometers after each use with sanitizer. In a policy provided by the DON who indicated this is their current policy, on 11/3/11 at 9 A.M. titled ' Infection Prevention in the use of Point of Care Testing: Policy and Procedure' indicated to use the manufacturer's instructions for cleaning and sanitation of glucometers. The Clinical Nurse Specialist provided the glucometer's manufacturer's guidelines on 11/4/11 at 9:25 A.M. The owner manual for the ARKRAY meter indicated, "...We suggest cleaning and disinfecting the meter between patient use..."		policy and procedure. II. Residents that receive glucometer checks by use of in house machine are at risk and have been identified. Residents will receive glucometer checks by use of a sanitized machine per policy and procedure. III. Education has been provided to all licensed nurses regarding policy and procedure of cleansing glucometer machine between each resident test. The systemic change is that nurses will complete disinfection after each use/test provided to a resident per policy and procedure then once allotted time completed, the glucometer will be placed in a plastic bag in preparation for next use. IV. The DON/Designee will audit use and disinfection of the glucometer 3 times per week for 2 months, then one time per week for 4 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of compliance – 12/04/11	

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F0514 SS=A	3.1-18(j) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately document a medication given for a resident with a diagnosis of insomnia. The deficient practice impacted 1 of 18 residents whose records were reviewed from a sample of 18. [Resident #3] Findings include: Resident #3's record was reviewed on 11/1/11 at 10:55 A.M. Diagnoses included, but were not limited to, insomnia, weakness, malaise and fatigue, and pain. A "Physician's Order" dated 9/29/11, no time, included, but was not limited to, "Discontinue Ambien, Halcion 0.125 milligrams if awake at 12 A.M..." A "Nurse's Note" dated 10/3/11 at 12 A.M. included, but was not limited to,	F0514	F-514 Resident records – complete/accurate/accessible I. Resident # 3 will receive accurate documentation in relation to what medication was administered. II. Residents in which are administered psychotropic medications are at risk and have been identified. These residents will receive nurses note documentation to accurately reflect the psychotropic medication administered as ordered by the Physician. III. Nurses have been educated on documentation of psychotropic medication to include nurses note documentation. The systemic change is that nurses will reference the Physician order or MAR when referring to psychotropic medications in nurses notes to ensure accuracy. IV. The DON/Designee will monitor nurses note documentation on 3 random patients that receive	12/04/2011

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	"Zolpidem given for insomnia..." On 11/2/11 at 9:30 A.M., the DoN [Director of Nursing] provided the "Controlled Drug Record" for Resident #3's Halcion indicating on 10/3/11, the correct dose of Halcion was given as ordered, not Zolpidem [Ambien], as documented in the nurse's notes. In an interview at that time, the DoN indicated she would have the staff member correct her error in charting to reflect the correct medication given. 3.1-50(a)(2)		psychotropic medications once per week for 2 months, then 3 random patients once every 2 weeks for 4 months. These audits will be reviewed and reported to the Quality Assurance Committee monthly for review and recommendation of further monitoring actions. V. Date of compliance – 12/04/11	